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## Home Care: Compassion or Corruption?

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# Nursing & HEALTH CARE

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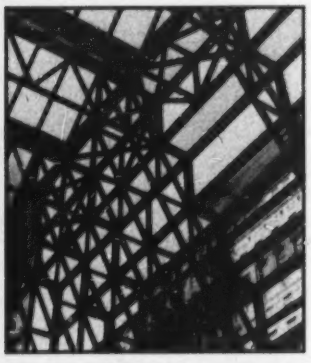


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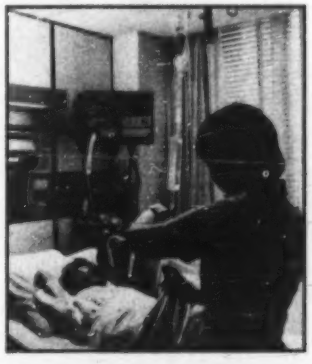


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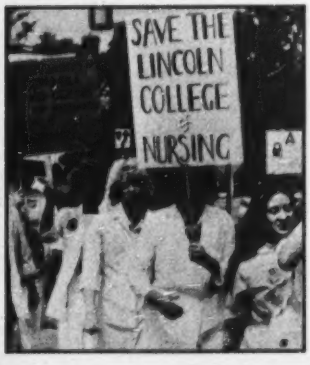



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NURSING & HEALTH CARE offers diverse views on subjects of interest to readers. Articles represent the opinions of individual contributing authors and are not necessarily those of the National League for Nursing.

# Nursing Education: Statistics You Can Use

**By Peri Rosenfeld, PhD**
**Director of Annual Surveys, NLN**

Over the past few years, nursing leaders' efforts have improved the political, social, and economic status of the profession. For example, the new National Center for Nursing Research promises to help nurses increase their influence on public policy and expand the body of nursing theory and research. Social changes affect contemporary nursing as well. Public- and private-sector cost containment initiatives have cut back the number of dollars available to pay for the nation's health care. The new environment gives nurses a wealth of opportunities to put their abilities to deliver cost-effective care into play. It also creates the challenge of trying to gain ground in a competitive marketplace.

At a time when the demand for highly skilled nurses to provide care in a variety of settings is growing, higher education has hit upon hard times. Enrollments are low, and nursing schools, along with other institutions of higher learning, are witnessing an influx of older, first-time students as well as returning students. These changes demand a rethinking of traditional teaching methods and curricula.

Under sharp economic constraints, nursing educators must take a hard look at how to teach students to rise to the new responsibilities that the efforts of the profession have won. The results of the National League for Nursing's (NLN's) 1984 Annual Survey of RN Programs offers data to help educators and policy makers plan for the demands of an altered marketplace.

The survey is a large-scale, year-long project. Each fall, NLN's research department revises the previous year's questionnaire, clarifying unclear questions and writing new ones to cover new issues. The researchers then send a survey packet to every nursing school in the United States and territories that prepares registered nurses (RNs).

Nursing education is now well-established in the higher education community. In 1984, 82 percent of all 1,477 basic nursing programs were affiliated with community colleges, four-year colleges, or universities. Of these, 777 offered an associate degree in nursing and 427 offered a baccalaureate degree. The remaining 273 nursing programs (18 percent of the total) were hospital-based diploma programs.

The changing proportion of program types over the past 20 years proves there is trend toward higher education in nursing. The number of baccalaureate and associate degree programs has increased steadily during the past two decades; the number of hospital-based diploma programs continues to decline. In 1965, diploma programs outnumbered baccalaureate programs 4-to-1 and associate degree programs almost 5-to-1. The 1975 picture was closer to the one we see today: there were 608 associate degree, 326 baccalaureate, and 428 diploma programs.

A breakdown of program type by NLN region indicates that, in the North Atlantic region, each type represents approximately one-third of the total: of the 357 programs, 30 percent are baccalaureate, 38 percent are associate degree, and 32 percent are diploma. All other regions report that the largest portion of their programs grant associate degrees: 47 percent of the programs in the Midwest, 59 percent of the programs in the South, and 74 percent of the programs in the West. Diploma programs make up the smallest proportion of programs in all regions except the North Atlantic: 24 percent in the Midwest, 10 percent in the South, and 2 percent in the West.

The proportion of program types within regions has changed most drastically in the North Atlantic and Midwest over the last decade. In 1975, 50 percent of the 402 programs in the North Atlantic were diploma, 28 percent associate degree, and 23 percent baccalaureate. Of the 388 Midwestern programs, 38 percent were diploma, 39 percent associate degree, and 23 percent baccalaureate. More modest changes have occurred in the South and West, but these regions do not have the long tradition of hospital-based diploma programs found in the other regions.

The survey's admission numbers include first-time nursing students admitted to a program between August 1983 and July 1984. Programs reported an overall increase of 3,245 students (2.7 percent), making the 1983–84 total 123,824. Broken down by program type, baccalaureate programs reported a 5.7 percent increase, associate degree programs reported a 4.1 percent increase, and diploma programs reported a 7.8 decrease percent in overall admissions.

From 1977–78 through 1979–80, annual admissions to RN programs fell. Although diploma programs experienced the greatest losses during that time, baccalaureate admissions also fell, and admissions to associate degree programs grew very little. Admissions have grown from 1980–81 on, perhaps due to more effective recruitment methods.

A look at the 10-year trend in annual admissions reveals that baccalaureate admissions have increased almost 13 percent since 1974–75, associate degree admissions jumped about 35 percent, and diploma admissions fell 28 percent.

Fall admissions decreased almost 4 percent, from 94,539 in 1983 and 91,085 in 1984. Since fall admissions make up approximately 70 percent of annual admissions, the reported drop signals the probability of lower enrollments in 1984–85.

As of October 15, 1984, enrollment figures reveal de-

**Summary Table of 5- and 10-Year Trends in Nursing Education: 1975–1984***

| Program | Number of Programs | | | Enrollments | | | Graduations | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1975 | 1980 | 1984 | 1975 | 1980 | 1984 | 1975–6 | 1979–80 | 1983–4 |
| Diploma | 428 | 311 | 273 | 60,213 | 41,048 | 37,256 | 19,861 | 14,495 | 12,200 |
| Associate Degree | 608 | 697 | 777 | 88,121 | 94,060 | 104,968 | 34,625 | 36,034 | 44,394 |
| Baccalaureate | 326 | 377 | 427 | 99,837 | 95,858 | 95,008 | 22,579 | 24,994 | 23,718 |
| Master's | 99 | 135 | 166 | 9,662 | 15,503 | 18,882 | 3,417 | 4,755 | 5,082 |
| Doctorate | 12 | 22 | 31 | 508 | 1,919 | 1,696 | 62 | 125 | 183 |

*Source: Nursing Student Centers with Policy Implications 1985. New York: NLN, 1986.

creases in all program types. Diploma programs experienced an 11.3 percent drop; baccalaureate and associate degree programs decreased about 4 percent each.

Enrollment trends over the past decade show that, in 1974, baccalaureate degree programs reported 94,413 enrollments, which was a continuation of their upward trend; associate degree programs reported 84,166 enrollees, which also represented an expansion in numbers; and diploma schools reported a continued decline, with 63,972 enrollees. By 1979, baccalaureate programs still led the pack in enrollments, but the gap between baccalaureate programs and associate degree programs narrowed signficantly, and the gap between those programs and diploma programs widened—there were 98,939 enrollments in baccalaureate programs, 92,069 in associate degree programs, and 43,651 in diploma programs. In 1981, for the first time, enrollments in associate degree programs outnumbered those in baccalaureate programs, and this trend is continuing.

Enrollments in other areas of higher education are also plummeting. In April, 1985, the American Council on Education (ACE) reported a sharp decline in enrollments at the community college level, and National Center for Education statistics predicts a slight decline in college enrollments [1,2]. The Association of American Medical Colleges also reported a drop in enrollments and applications for fall 1985 [3]. So, although nursing education has its own internal problems, other areas of higher and professional education are also feeling the impact of such external factors as the shrinking college-age population.

The total number of students graduating from basic RN programs rose 3.8 percent to 80,312 in 1984. The 23,718 baccalaureate graduations represented a 0.6 percent decline over 1983. Associate degree graduations rose 6 percent to 44,394, and diploma graduations rose 4 percent.

The five-year trend reveals that the number of graduations from generic baccalaureate programs has been declining continually since 1979–80, when the total was 25,048. Associate degree graduations, which have been waning and waxing during the last five years, reached a high point in 1983–84, but the increases are modest when compared with the 30 percent gains registered each year during the 1960s and 1970s. The rise in the number of graduations from diploma programs can be explained by the rise in admissions in 1980 through 1983.

The pool of nursing students preparing for RN licensure reached its apex in 1983–84. From 1975–76 to 1979–80, the number of basic nursing graduates had remained in the high 70,000s; the past few years witnessed small fluctuations; and the current surge brought the number of graduates up to 80,000. However, we expect that graduations from diploma programs will continue to decline after two years of small increases. In light of declining enrollments and fall admissions, graduations from associate degree programs may stabilize in the next few years, and generic baccalaureate graduations will probably not outnumber their 1978–80 heights. In short, it's unlikely that we will see numbers of graduations as high as the current number in years to come.

Because the NLN and the American Nurses' Association have both endorsed the baccalaureate degree as the professional credential for nursing, we will probably see more nurses returning to school to earn baccalaureate degrees. But returning students also reflect an overall trend in higher education. According to a study of attitudes toward higher education reported in the newsletter *Higher Education and National Affairs*, increasing numbers of Americans are planning to upgrade their educations [4].

We should also consider the phenomenon of nurses returning to school in the context of the growing numbers of nontraditional college students. According to a report of the College Board, today's urban student is more likely to be female, over 25 years of age, and enrolled part-time [5]. These adult learners have special needs that educators in all fields will have to meet.

During the last 10 years, RN enrollments in baccalaureate programs have boomed. The number of RNs entering generic baccalaureate programs in nursing with a track for returning RNs grew from 10,653 in 1975 to 22,520 in 1984. The number of RNs entering special programs designed specifically for them rose 261 percent, from 5,063 in 1975 to 18,552 in 1984.

The combined enrollments of both basic and RN students in baccalaureate programs is 136,120: 70 percent are basic students, 16 percent are RNs in generic programs, and 14 percent are RNs in special programs designed for RNs. Most of the RNs are part-time students: 70 percent of those in generic programs are enrolled part time, and 74 percent in special programs are part-time students. Basic baccalaureate students are more likely to be full-time enrollees, only 10 percent are part-time students.

Regional data shows that 40 percent of the RNs enrolled

in generic programs are in the North Atlantic region, 25 percent are in the Midwest, 20 percent are in the South, and 15 percent are in the West.

The 10-year trend in the number of returning RN graduations is as dramatic as the enrollment figure. In 1974–75, 3,165 RNs graduated from generic baccalaureate programs. That figure rose to 6,275 in 1983–84. Graduations from special programs increased from 598 in 1974–75 to 3,810 in 1983–84. About equal numbers of RNs graduating from baccalaureate programs had diploma or associate degrees as their previous nursing credential.

The number of men enrolled in all types of nursing programs has increased steadily since 1978. In 1984, men accounted for 6.2 percent, or 13,652, of total enrollments in RN programs. Overall, about 3 percent of nurses are male.

The nursing student population, in addition to being largely female, is largely white. About 7 percent, or 15,363, of the 1984 enrollees were black. An additional 2 percent—4,410—were Hispanic, 1.6 percent—3,594—were Asian, and less than half a percent—880—were American Indian.

The proportion of minority nursing students our survey revealed is slightly lower than that reported by the United States Department of Education for undergraduate enrollments in institutions of higher education: blacks accounted for almost 10 percent of all enrollments, Hispanics for 4.4 percent, Asians for 2.7 percent, and American Indians for 0.7 percent [6].

Baccalaureate programs reported the highest percentage of black (6.5 percent) and Asian (2.2 percent) student enrollments. Associate degree programs reported the highest proportion of men (6.5 percent) and American Indians (0.6 percent). Diploma programs ranked third in all categories. These figures suggest that all types of nursing programs should step up efforts to recruit minority students.

Today's economic and demographic circumstances have created a need for nurses in expanded roles. A 1983 Institute of Medicine report revealed that there are insufficient numbers of nurses prepared at the graduate level to do research, serve as administrators and managers of clinical services in health care institutions, and practice in clinical specialties [7].

The data on graduate nursing education reveals that programs are working to meet the rising demand—the numbers of students enrolled in both master's and doctoral programs has increased. In 1984, the United States had 31 doctoral programs in nursing and 168 programs that granted master's degrees in nursing. Enrollments in doctoral programs jumped more than 13 percent, to 1,696, and enrollments in master's programs increased 4 percent to 18,822. Graduation figures reveal a similar pattern: the number of graduates with master's degrees increased 1 percent to 4,082, and 183 nurses received doctorates—a 32 percent increase over 1983.

Ten years ago, 12 doctoral nursing programs had 506 total enrollments and 74 graduations. In 1979, there were 980 enrollments and 125 graduations. Enrollments grew more than 200 percent, and graduations jumped almost 150 percent in the last decade.

The 5- and 10-year trends in master's education show that the number of programs increased from 99 in 1975 to 125 in 1979, and to 166 in 1984—a 68 percent increase in a decade. Enrollments increased from 8,584 in 1975 to 14,994 in 1980, and to 18,822 in 1984. Graduations jumped from 2,678 in 1974–75 to 4,755 in 1979–80, and to 5,082 in 1983–84.

The majority of master's students—81 percent—are preparing for advanced clinical placement. Seven percent are preparing for teaching; 11 percent are preparing for administration. The pattern we found among graduates is similar.

Approximately 15 percent of the master's program enrollees and graduates were in formal nurse practitioner programs, which we define as "an organized educational program consisting of formal classes and clinical practice designed to prepare registered nurses to perform in an expanded role in the delivery of primary health care." Family and adult health were the most popular specialty areas; small percentages of students specialized in pediatrics, gerontology, and midwifery. Given the growing numbers of elderly persons in this country, and the growing emphasis on community-based care, we expect there will be a greater demand for nurse practitioners in gerontology community health in years to come.

Contemporary nursing education must handle the internal professional demands of increased credentialing and the image of nurses while dealing with the challenges posed by external developments, such as the health care budget crunch, demographic shifts, and changes in higher education.

The data on nursing education programs helps point out some of the obstacles nursing faces—such as falling enrollments and fall admissions, as well as decreasing proportions of minority students. Educators have expressed concern about retaining nursing students, and this concern is partially borne out by the data on decreasing enrollments during times of increased admissions. Furthermore, fears of a nursing shortage may be supported by the possible decrease in graduations in the next few years. On the other hand, particularly in the area of higher degrees, there is encouraging news on RNs returning to school, and on enrollments in master's and doctoral programs. We hope these data will provide insights to help plan the future of the professions and to spur discussion among nursing leaders.

*A full report of the annual survey appears in* Nursing Student Census with Polity Implications 1985, *which is available from the Publications Order Unit, National League for Nursing, 10 Columbus Circle, New York, NY 10019, 800/847-8480, in New York, 800/442-4546.*

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Jane Doe, RN

## Opening the Door on Nursing's Cost Advantage

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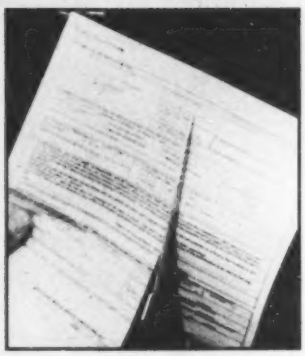

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# Opening the Door on Nursing's Cost Advantage

CLAIRE M. FAGIN

The health care system in the United States is in the midst of revolutionary change. The language of change includes such words as *cost containment, deregulation, diagnosis related groups, preferred provider organizations, independent practice associations, managed care*, and *peer review organizations*. However, the real change is a change in ideology spurred by the privatization of health care services. Access to care, once providers' paramount concern, now competes with their attention to the bottom line.

Nurses should be at the heart of any planned system change that will enhance cost-effectiveness. There is strong evidence that nurses and nursing care can affect patient outcomes positively, both in and out of hospitals, and that nursing services can contribute immeasurably to the goals of a competitive health care delivery system. Because of these findings, some public officials and business people have encouraged insurers and the government to reimburse nurses for their services. On the other hand, a number of forces have worked to deter nurses from entering the more autonomous health care marketplace. The net effect of the changes in the health care scene is far from clear. However, the new environment provides opportunities for nurses to increase our impact on the delivery system. The following facts about today's health care scene are particularly relevant to nurses' interests and expertise [1]:

**Declining mortality rates** Over the past decade, mortality rates have declined rapidly for all ages and both sexes. This is an unprecedented phenomenon following two decades of stationary rates for men and slowly declining rates for women [2]. Some scientists attribute this change to early diagnosis and treatment of life-threatening diseases; others believe it results more from improved self-care or healthier life-styles than from medical therapies or technologies [3].

**Higher morbidity rate** Paralleling the lowered mortality rate has been a higher morbidity from infancy through old age and a worsening health profile for middle-aged and older people. People aged 45 years and older experience fewer acute conditions than younger people, but spend more days caring for these acute conditions and suffer from a variety of chronic situations. The leading chronic conditions for men and women are hypertension, arthritis, and sinusitis [4].

**The over 65 population** About 12 percent of our present population is aged 65 years or older. As recently as 15 years ago, census experts had not foreseen this dramatic demographic change.

**The escalation in health care costs** In the past five years, health care costs have risen at a rate almost three times that of the general inflation rate. Elderly persons account for about one-third of all health care expenditures, and up to 30 percent of all Medicare payments are for care in the last year of life. However, analysts do not see the growth in the elderly population as the main reason for cost escalation. Rather, according to a report from the Office of Technology Assessment, the "dramatic increases are largely due to intensification of services, expanded availability and use of costly diagnostic and treatment services and technologies, and the rising cost of labor. This excessive inflation in health care costs has led to concerted efforts to contain spending, which have far-reaching implications [for all of us and particularly] for older Americans [5]."

**Prospective payment** The fears of the policymakers at the Health Care Financing Administration (HCFA), which were generated by the possible bankruptcy of the Medicare Trust Fund, led them to devise a new way to pay hospitals for the services they provide to Medicare patients. The prospective payment system (PPS) that was put in place on October 1, 1983 sent shock waves throughout the system. HCFA policymakers are now talking about reducing or eliminating financial support

Claire M. Fagin, PhD, RN, FAAN, is the dean of the School of Nursing at the University of Pennsylvania in Philadelphia.

for graduate medical education, reducing physicians' fees under Medicare, reducing hospital rates, and applying diagnosis related groups (DRGs)—the patient classification system on which PPS is based—to physician payments. Although PPS only affects Medicare, it has added impetus to the concerns of other third party payers to contain costs. To date, only five states have instituted all-payer systems that mandate some form of prospective payment, but we anticipate acceleration in this movement. Both Representatives Richard A. Gephardt (D-Missouri) and Senator Edward M. Kennedy (D-Massachusetts) have introduced legislation to create all-payer rate setting systems throughout the United States.

***Table 1. Patient Economic Exposure Under Private Health Insurance, 1982–1984***

| | 1982 | 1984 |
|---|---|---|
| Percentage of insurance plans requiring front-end deductible for inpatient hospital charges | 39% | 63% |
| Percentage of insurance plans requiring front-end deductible for inpatient surgical changes | 34% | 59% |
| Percentage of insurance plans where annual deductible total per family of $200 or more | 4% | 21% |
| Percentage of insurance plans paying 100 percent of hospital charges for first days of hospital stay | 67% | 42% |
| Percentage of insurance plans paying 100 percent of surgical fees | 42% | 26% |

*Source: Hewitt Associates Company,* Company Practices in Health Care Cost Management, *1984. Companies sampled = 1185; Summary Table: Goldsmith, J., Death of a paradigm,* Health Affairs, *3(3), 1984.*

## Attitude Changes

All of this activity has changed the way people think about the delivery system and has led to the rapid growth of the for-profit sector in health care delivery. Until recently, health care was seen as a public good that should be available to all Americans in some form, regardless of their ability to pay. The marketplace is now challenging this idea, and that challenge is getting less notice than we might have expected. People are paying a great deal of attention to the changes brought about by PPS without recognizing that many of the changes that affect costs occurred before PPS was put in place. Either prior to or concurrent with the federal initiative, corporations, third party payers, and other organized, well-funded groups had begun to change health benefit packages to bring costs down.

Hewitt Associates, an international firm of consultants in compensation and employee benefits, surveyed 1,185 companies in 1982 and in 1984 to discover whether they were changing their health care cost management efforts [6]. They discovered that companies have been aggressively redesigning plans to increase employee cost sharing, and that the number of firms requiring employees to pay deductibles almost doubled during that period (see Table 1). Hewitt Associates also found significantly increased employer intervention in employee decisions about medical care in the form of required preutilization reviews and second opinions (see Table 2). These changes, coupled with a May 1985 recommendation by the U.S. Treasury Department that all workers pay taxes on a portion of their health insurance benefits, show an almost complete about-face in attitudes toward employee health and benefits [7].

## Market Changes

Clearly, health care buyers are pushing rapid and dramatic changes. The way providers are responding to market forces runs the gamut from either paralysis or helter-skelter activity to a targeted business approach to create new markets or to gain a share of the changing market through competitive pricing and service and to siphon the paying portion of the existing market from the already beleaguered public and voluntary sector. As examples, private ambulatory care centers—dubbed urgicenters, emergicenters, medical care walk-in centers, and docs-in-a-box—are cropping up around most middle class urban and suburban areas, which already had plenty of providers available. And even the home health segment of the marketplace, which has been seen as a nonprofit enterprise in the true sense of the phrase, has experienced an infusion of for-profit activity. Visiting nurse associations (VNAs) and public health departments have long offered high-quality services at low costs, and for-profit organizations' initial entries into this field were not successful. That situation has changed radically. VNAs and public health departments held an 85 percent share of the market in 1966. That share had declined to 37 percent by 1984. VNAs' share alone dropped from 39.7 percent in 1966 to 11 percent in 1984. Proprietary home health organizations have made large strides in penetrating the market during the past three years (see Table 3).

Ours, then, is a health care system facing a revolution fueled by an increasingly older population, necessary changes in primary focus from cure to care, changing values about who gets how much care, alternative health care systems and providers, and extraordinary growth in for-profit providers.

## The Nursing Scene

On the most simple level, both the social and the systems changes should create enormous reliance on the skills and attitudes that form the heart of nursing. We should not be surprised, however, that we are progressing by fits and starts. Although we are gaining ground in battles to win direct reimbursement from state and national programs, we continually face both challenges to such inclusions and the threat of physicians' incursion into nursing areas. Data support our bid for direct payments and expanded roles, showing the effectiveness of a wide variety of nurse practitioners in meet-

ing health care needs at a high level of quality and acceptance, and often at lower costs than other providers [8,9]. In fact, a recent survey revealed that, of the sampled populations, 63 percent of the public cross section, 59 percent of the hospital administrators, and 73 percent of the union leaders deemed acceptable a system change that would encourage the use of nurse practitioners and midwives rather than physicians [10]. Among physician leaders, 75 percent considered such a change unacceptable.

The reaction of organized physician groups to major and minor changes in state and federal laws that would prompt consumers to use nurse practitioners and other alternate providers is not surprising. Even when access to physicians was a problem, physicians' organizations condemned expanded roles for nurses. Now the American Medical Association has expressed concern about "a doctors' glut, and an impending oversupply of physicians in all specialities [11]."

## Successes

Nurses have made some important strides despite strong physician pressure to block us from being included in reimbursement programs. For example, during 1985 and 1986, the number of states with health insurance laws that mandate reimbursement for nurses' services increased. And nurses have several strong supporters in Congress who are working to help us progress. In May 1986, Representative Mary Rose Oakar (D-Ohio) reintroduced legislation that would allow direct reimbursement to nurse practitioners, nurse anesthetists, certified nurse midwives, and certified registered nurses under the Federal Employee Health Benefits Program (FEHBP). President Reagan vetoed the FEHBP bill in 1985 on the advice of organized medicine, but, at this time, the reintroduced bill has 24 sponsors.

Representative Richard Gephardt supports eliminating the tax exemption for employer paid health insurance benefits because he believes the money gained would be better used to provide health care for uninsured Americans. Gephardt plans to introduce legislation that would permit registered nurses to be paid by Medicare Part B for services they provide without direct supervision by physicians. He hopes this measure will encourage nurses to form independent group practices, which ultimately would reduce hospital use by making low-cost preventive care available and, therefore, more attractive to consumers.

*If nurses do not capitalize now on the dramatic changes in the health care marketplace, there is no doubt that other providers will. We have to be sure that we do not sit back and watch as other health care professionals take steps to meet the country's changing health care needs.*

Corporate concern about the high cost of care has also increased consumer access to nurse providers. Corporate cost containment efforts have led to many changes in benefits packages, as well as to a variety of innovative health care delivery packages. Such managed care systems as health maintenance organizations and preferred provider organizations generally bid to provide services for employees in local industries at capitated rates. National networks of health care companies, called super-meds, serve corporations with multiple locations. All of these programs make extensive use of a wide variety of nursing services in direct care, review, and marketing.

The number of nurses who are taking matters into their own hands and beginning entrepreneurial ventures also continues to grow. Many of these nurses are making themselves more visible, meeting with colleagues who share their interests and problems and consulting others interested in combining nursing with business. The June 1986 American Nurses' Association convention marked the first time a special interest group of such nurses met on a national level.

Although we can expect growth in the number of nurses in nontraditional roles, we should also be aware that hospitals are a major arena in which nurses can make the most of our cost advantage. Sixty-eight percent of registered nurses worked in hospitals in late 1984. Getting the most from our cost advantage requires continuing efforts to find acceptable cost accounting

***Table 2. Employer Intervention in Physician Decision Making, 1982–1984***

| | 1982 | 1984 |
|---|---|---|
| Percentage of firms requiring preadmission utilization review | 2% | 26% |
| Percentage of firms requiring concurrent hospital utilization review | 8% | 34% |
| Percentage of firms requiring retrospective hospital utilization review | 18% | 40% |
| Percentage of firms paying 100 percent of cost for second surgical opinion | — | 53% |
| Percentage of firms mandating a second surgical opinion | — | 28% |

*Source: Hewitt Associates Company,* Company Practices in Health Care Cost Management, *1984. Companies sampled = 1185; Summary Table: Goldsmith, J., Death of a paradigm,* Health Affairs, *3(3), 1984.*

systems that will allow us to develop our own cost and revenue centers. Community health nursing leaders attest to the fact that they have always had to measure nursing productivity and manage cost and revenue directly. Many writers now are stressing the importance of measuring nurses' contributions in hospitals. Ann van Slyck has said "it is apparent that, as nurses, our vulnerability is in part a result of previous attempts to justify our existence with quality-of-care arguments alone. We are now finding it necessary to justify our services financially—from a cost benefit perspective [12]." Franklin A. Shaffer points out that nursing is in its second generation of attempts to price our products [13].

We are in the process of building our documentation of nursing interventions and costs that can provide the data necessary for third party reimbursement for nursing care in any setting. Examples include continuing study of the use of RN staff members in delivering nursing care, documenting the effectiveness of broad use of hospital-employed nurses for preadmission and postdischarge care or monitoring, and developing new systems for measuring nursing intensity and case management.

## Suggestions

For nurses to take full advantage of the cost-effectiveness of the services we provide, our momentum for progress must continue into the future. To keep that momentum strong, we should give special attention to certain areas. First, the question of third party reimbursement is murky at best. Nurses are struggling to obtain direct reimbursement at a time when fewer physicians are receiving direct payment. About 40 percent of the physicians practicing today are salaried, and this percentage is quickly rising. Government program leaders are strongly averse to reimbursing new providers because they believe that doing so will thwart their cost cutting goals. Therefore, we must continue to gear our political actions for reimbursement in revenue neutral formats—that is, we must convince program leaders that our being paid directly for services will not lead to higher budget outlays. In the area of nursing homes, where we are working to improve the quality of care being provided, it may be difficult to maintain revenue neutrality if we win appropriate reimbursement for our efforts. Despite the difficulties, this is an area in which the public requires that we keep our efforts strong.

***Table 3. Medicare-Certified Home Health Agencies by Sponsor***

| Sponsor | 1966 | 1976 | 1984 |
|---|---|---|---|
| Visiting Nurse Association | 39.7% | 20.3% | 11% |
| Government | 45.4% | 49.7% | 26.3% |
| VNA, Government, Combined | 91.6% | 71.8% | 38.5% |
| Proprietary | — | 3.7% | 27% |

*Sources: Department of Health, Education and Welfare, Health Care Financing Administration, Medicare-use of home health services: 1976,* Health Care Financing Statistics, *May 1980. Proprietaries pass officials in Medicare-certified HHA,* Home Health Line, *July 23, 1984. Stewart, J.,* Home Health Care, *Mosby, 1979. Vogel, R., and Palmer, H., Long-term care: Perspectives from research and demonstration, Department of Health and Human Services, Health Care Financing Administration, 1983.*

Second, nurses must show evidence that we can provide quality care not only directly, but also indirectly through patient education. Capitation systems limit the cost of care to a fixed price per person each year. All delivery systems that receive capitated payments want to provide quality service to as many patients as possible at the lowest cost. A hallmark of such programs is to enhance the ability of patients and families to manage more of their own care and to require fewer services. For decades, nurses' educational programs have stressed self-care—helping people analyze the factors that affect their health and well-being and take actions that will change these factors. As clients assume more responsibility for their own health, their reliance on the health care system will be reduced.

It makes sense for managed care systems to delegate as much as possible to less expensive providers. There is strong evidence that nurse midwives and nurse practitioners provide high quality, highly accepted care at less cost than do physicians. In many instances, the care is more holistic and health promoting and uses fewer high-cost procedures and less hospitalization. Nurses' strategies for growth should include making certain that the owners and managers of these delivery systems are fully informed about the cost and quality advantages of employing nurses.

Third, the hospital marketplace now offers a wealth of opportunities for highly skilled nurses. Contrary to early predictions that declining occupancy rates would reduce hospital employment opportunities for nurses, increased patient acuity has upped hospitals' needs for registered nurses while lowering the need for nonprofessional personnel. Hospital-based RNs can also take the lead in planning care for the total illness episode—discharge planning, rehabilitation, home care, and long-term care are all within nursing's realm of professional knowledge. Thus, nurses must capitalize on professional knowledge during times of major structural changes.

Another important market for nurses to target is community- and corporate-based wellness programs. These programs offer education on prevention, increase health related behaviors, and discover and mitigate risk factors. Occupational health nurses, school nurses, and community nurses must increase their activities in these spheres either as part of their current work mode or through volunteer activities. Such activities will increase the visibility of nurses and will demonstrate their skill in developing, collaborating with, and implementing such programs.

Finally, if nurses do not capitalize on the opportunities in the changed marketplace, there is no doubt that other providers will. We have to be sure that we do not sit back and watch as others meet the country's changing health care needs.

## Conclusion

The continued blurring of roles in primary health care, the glut of physicians in the marketplace, and the creation of new markets and new roles are complex factors that will influence

nurses' efforts to make the most of our cost advantage. We can and must address recent aggressive entries of physicians into geriatric care and home care, as well as the continued testimony of physicians against liberalizing state and national programs to include nurse practitioners. We have a number of political allies interested in opening the health delivery system to us and to other credentialed providers. It is our responsibility to collect the data to support and monitor change in order to protect the integrity of the profession and the health of the public.

The facts about today's health care scene—the higher chronicity, the increased percentage of aged persons in the population, the public's recognition of the importance of leading healthier lives and taking steps to prevent illness, and everyone's interest in keeping costs down—force us to take a new look at our profession. We have appropriately cherished our concern with quality; finally we can blend it with a concern for gaining autonomy, recognition, and suitable compensation. Individual nurses and nursing leaders can push the profession ahead by continuing to capitalize on the new climate in health care.

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